441—73.3 (249A) Enrollment.

73.3(1) *Enrollment area.* The coverage area for enrollment shall be statewide.

73.3(2) *Members subject to enrollment.* All HAWK-I program and Iowa Health and Wellness Plan members shall be subject to mandatory enrollment in a managed care organization. All Medicaid members, with the exception of the following, shall be subject to mandatory enrollment in a managed care organization:

a. Members who are medically needy as defined at 441—subrule 75.1(35).

b. Individuals eligible only for emergency medical services because the individuals do not meet citizenship or alienage requirements, pursuant to 441—subrule 75.11(4).

c. Persons who are currently presumptively eligible as defined in 441—subrules 75.1(30), 75.1(40), and 75.1(44).

d. Persons eligible for the program of all-inclusive care for the elderly (PACE) who voluntarily elect PACE coverage as defined in 441—subrule 88.24(1).

e. Persons enrolled in the health insurance premium payment program (HIPP) pursuant to rule 441—75.21(249A).

f. Persons eligible only for the Medicare savings program as defined in rules 441—75.1(249A) and 441—76.1(249A).

g. American Indian and Alaska Native populations who are exempt from mandatory enrollment pursuant to 42 CFR 438.50(d)(2) but who may enroll voluntarily.

73.3(3) *Enrollment process.* The department shall notify members who must be enrolled in a managed care organization of enrollment and the effective date of enrollment. The department will implement an enrollment process in accordance with federal funding requirements, including 42 CFR 438 as amended to October 16, 2015.

a. General. Members may receive managed care organization choice counseling from the enrollment broker. The enrollment broker will provide information about individual managed care organization benefit structures, services and network providers, as well as information about other Medicaid programs as requested by the Medicaid member to assist the member in making an informed selection.

b. Tentative assignment. Members shall be tentatively assigned to a managed care organization and offered the opportunity to choose from the available managed care organizations within a time frame specified in the tentative assignment letter.

c. Request to change enrollment.

(1) A member shall have a minimum of ten days from the date of the tentative assignment letter to request enrollment with a different managed care organization. The request may be made on a form designated by the department, in writing, or by telephone call to the enrollment broker's toll-free member telephone line. Changes are subject to the effective date provisions of subrule 73.3(4).

(2) An enrollee may, within 90 days of initial enrollment, request to change enrollment from one managed care organization and enroll in another managed care organization. The request may be made on a form designated by the department, in writing, or by telephone call to the enrollment broker's toll-free member telephone line. Changes are subject to the effective date provisions of subrule 73.3(4).

d. Ongoing enrollment. Enrollees shall remain enrolled with the chosen managed care organization for a total of 12 months.

e. Enrollment cycle. Prior to the end of the enrollee's annual enrollment period, the enrollee shall be notified of the option to maintain enrollment with the current managed care organization or to enroll with a different managed care organization.

73.3(4) *Effective date of enrollment.* The effective date of enrollment shall be no later than the first day of the second month beginning after the date on which the managed care organization receives the designated managed health care choice form or written or verbal request.

73.3(5) *Benefit reimbursement prior to enrollment.*

a. Prior to the effective date of managed care enrollment, except as provided in paragraph 73.3(5)*"b,"* the Medicaid program shall reimburse providers for covered program benefits pursuant to 441—Chapters 74 to 91, as applicable for eligible members.

b. The managed care organization shall be responsible for covering newly retroactive Medicaid eligibility periods, prior to the effective date of enrollment, in the following cases:

(1) Babies born to Medicaid-enrolled women who are retroactively eligible to the month of birth; and

(2) Children enrolled in the HAWK-I program retroactive to the date of application. For purposes of this requirement, a retroactive Medicaid eligibility period is defined as a period of time up to three months prior to the Medicaid determination month.

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